

Welcome

Young Adult

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOU: Today's Date: _____

Name: _____
Last First Mi

Nickname: _____ Male Female

Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

College: _____ SS #: _____

E-mail Address: _____

Hobbies / Sports: _____

Home Phone: (____) _____

Home Address: _____

City State Zip

Whom may we Thank for referring you? _____

Previous / Present Dentist: _____
(Please Circle)

Last visit date: _____

Other family members seen by us with Birthdate:

Name Birthdate

_____/_____/_____
_____/_____/_____
_____/_____/_____

Who is responsible for making appointments?

Name: _____ Relation: _____

Work Phone: (____) _____

Home Phone: (____) _____

Primary Dental Insurance:

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Policy Owner: _____

Policy Owner's Birthdate: ____/____/____ SS #: _____

Policy Owner's Employer: _____

Employer's Address: _____

City State Zip

Parent Information:

Who is accompanying you today? _____

Name: _____ Relation: _____

Does this person have legal custody of you? Yes No

Parent's Marital Status: _____ (Please Circle)

Single Widowed Married Divorced Separated Partnered

Mother's Information: Step Mother Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

Wk Phone: (____) _____ Hm Phone: (____) _____

Cell Phone: (____) _____ SS #: _____

Employer: _____

Father's Information: Step Father Guardian

Name: _____ Birthdate: ____/____/____

Email Address: _____

Wk Phone: (____) _____ Hm Phone: (____) _____

Cell Phone: (____) _____ SS #: _____

Employer: _____

Person Responsible For Account:

Name: _____ Relation: _____

Employer: _____ DL #: _____

Wk #: (____) _____ Cell #: (____) _____

Billing Address: _____

City State Zip

Previous Address: _____

City State Zip

Secondary Dental Insurance:

Orthodontic Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Policy Owner: _____

Policy Owner's Birthdate: ____/____/____ SS #: _____

Policy Owner's Employer: _____

Employer's Address: _____

City State Zip

CONTINUED ON BACK

Why have you come to the dentist today? _____

Have you experienced problems with previous dental work? Yes No

Is your water fluoridated? Yes No

Are you taking fluoridated supplements? Yes No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)? Yes No

Do you brush your teeth daily? Yes No

Floss your teeth daily? Yes No

Do your gums bleed? Yes No

Do you require antibiotics before dental work? Yes No

Have you ever taken Phen-Fen? Yes No
Also known as Redux or Pondimin. If so, when? _____

Are you currently under a physician's care? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Please describe your current physical health:
 Good Fair Poor

Please list all drugs that you are currently taking: _____

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Unsure Week #: _____

Are you nursing? Yes No

For orthodontic treatment please complete the following:

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated/had orthodontic treatment before? Yes No

Have there been any injuries to your face, mouth, teeth or chin? Yes No

Have adenoids or tonsils been removed? Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Do you still have your wisdom teeth? Yes No

Have you played any musical instruments? Yes No
If so, what? _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Y N Aspirin
- Y N Any Metal / Jewelry
- Y N Plastic
- Y N Codeine
- Y N Dental Anesthetics
- Y N Erythromycin
- Y N Latex
- Y N Penicillin
- Y N Tetracycline
- Y N Other

Please list any other Allergies that you have _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- Y N Abnormal Bleeding
- Y N Anemia
- Y N Any Hospital Stays
- Y N Artificial Bones / Joints
- Y N Asthma
- Y N Cancer
- Y N Chicken Pox
- Y N Congenital Heart Defect
- Y N Convulsions / Epilepsy
- Y N Diabetes
- Y N Handicaps / Disabilities
- Y N Hearing Impairment
- Y N Heart Murmur
- Y N Hemophilia
- Y N Hepatitis
- Y N Hives
- Y N HIV+ / AIDS
- Y N Kidney Problems
- Y N Liver Problems
- Y N Lupus
- Y N Measles
- Y N Mononucleosis
- Y N Mitral Valve Prolapse
- Y N Rheumatic / Scarlet Fever
- Y N Skin Rash
- Y N Tuberculosis (TB)

DID/DO YOU EXPERIENCE ANY OF THE FOLLOWING?

- Y N Nursing Bottle Habits
- Y N Speech Problems
- Y N Thumb / Finger Sucking
- Y N Tongue Thrust
- Y N Clenching / Grinding Teeth
- Y N Lip Sucking / Biting
- Y N Mouth Breather
- Y N Nail Biting
- Y N Were you breastfed?
- Y N Used Pacifier

Are your Immunizations current? Yes No

Please discuss any serious medical problems you've experienced:

Is there anything you would like to discuss with the doctor in private? Yes No

I understand that I am responsible (if 18 yrs or older) for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance or my parent's insurance does not cover.

Patient Signature Date

Parent/Guardian Signature (if Necessary) Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature of Patient and/or Parent/Guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of Patient and/or Parent/Guardian Date

The Patient or Parent/Guardian is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: ____/____/____
Doctor's Comments: _____
